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<title>**Globalization and Health**</title>

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Like many terms that describe macro-scale social processes, *globalization* is subject to definitional controversy. The anthropologist Arjun Appadurai has characterized it as involving "global cultural flow" (1990, 296) in multiple dimensions that he calls ethnoscapes, mediascapes, technoscapes, finanscapes, and ideoscapes. A more recent and nuanced discussion by the international relations scholar Jan Aart Scholte refers to globalization as "a change in social space that is both quantitatively and qualitatively significant," with "social connections that substantially transcend territorial geography," compressing both space and time, playing a central role (2008, 10, 21). These connections include worldwide connectivity provided by the Internet (in "cyberspace"); low-cost and high-speed passenger and freight transportation; reorganization of production across multiple national borders; and emergence of financial markets in which large volumes of capital circulate almost instantaneously, in forms that are at least partly independent of territorial location. Both Appadurai (2000) and Scholte (2005) have elsewhere emphasized the economic dimensions of globalization, suggesting the value of the definition preferred by the present author: "[a] pattern of transnational economic integration

animated by the ideal of creating self-regulating global markets for goods, services, capital, technology, and skills" (Eyoh and Sandbrook 2003, 252).

Direct health consequences of globalization, defined multidimensionally, are both negative and positive. The negatives include increased ease and speed of communicable disease transmission, as illustrated by the SARS epidemic (Fidler 2003) and continuing concern about new and virulent forms of influenza. The most conspicuous positive consequences involve the worldwide diffusion of advances in medical technology, epitomized since the 1990s by measles immunization campaigns that lowered the annual death toll in low- and middle-income countries (LMICs) from an estimated 872,000 deaths in 1990 to 118,000 in 2008 (van den Ent, Brown, Hoekstra, et al. 2011) and the twenty-fold increase between 2003 and 2011 in the number of people in LMICs receiving antiretroviral (ARV) therapy for HIV infection (UNAIDS 2012). These accomplishments were, and are, not independent of economic considerations and economic policy. Each required substantial expenditure on the part of the high-income world, and in the aftermath of the 2008 economic crisis the continuation of that expenditure was under threat (Moszynski 2011; van den Ent, Brown, Hoekstra, et al. 2011). Because of previous commitments to harmonize intellectual property (IP) protection under the World Trade Organization's 1995 Agreement on Trade-Related Aspects of Intellectual Property (TRIPS), expansion of ARV coverage would not have been possible without a hard-fought transnational battle to bring down the prices charged by pharmaceutical companies for patented ARVs using the threat of generic competition (von Schoen Angerer, Wilson, Ford, and Kasper 2001; Holmes, Coggin, Jamieson, et al. 2010).

Further complexity is introduced by social determinants of health: conditions of life and work that make it relatively easy for some people to live long and healthy lives, with the same

outcome being all but impossible for others. Access to medicines and health care is only one among many such determinants; their unequal distribution within and among nations was central to the work of the World Health Organization (WHO) Commission on Social Determinants of Health (2008). Economic integration is emphasized as a defining characteristic of globalization by Dickson Eyoh and Richard Sandbrook; as that integration continues, it changes those conditions of life and work and therefore changes the distribution of opportunities to be healthy (Labonté, Schrecker, Packer, and Runnels 2009).

<h1>Globalization as Economic Integration, and the Implications for Health</h1>

Richard Feachem (2001) argued that globalization reduces poverty and is, therefore, conducive to health improvements. He was correct to identify poverty, however defined, as a primary threat to health (see also Farmer 2003; Paluzzi and Farmer 2005; Pogge 2007b). However, the analysis on which his argument rests is tenuous in several respects (Kawachi and Wamala 2007). These include a questionable basis for distinguishing "globalizer" from "nonglobalizer" countries based on changes in the ratio of trade to gross domestic product (GDP); a focus on trade liberalization to the exclusion of other dimensions of globalization, including external debt and other aspects of global finance; neglect of influences of trade liberalization on health that are not directly related to poverty; disregard of the uneven global distribution of poverty reduction; and the fact that worldwide progress on this front was modest during a quarter-century in which the value of the world's economic product quadrupled. Specifically, between 1981 and 2005, wherever in the world outside China someone escaped extreme poverty as defined by an income of $1.25 per day or less, adjusted for purchasing power parity—a World Bank definition that is itself problematic (Reddy and Pogge 2005; van Doorslaer, O'Donnell, Rannan-Eliya, et al. 2006)—someone else

fell into it (Chen and Ravallion 2008). On balance, the view that globalization's "savage sorting of winners and losers" (Sassen 2010) will have negative effects on health is persuasive. An innovative econometric exercise conducted as background for the WHO social determinants commission using health and economic data from 136 countries (Cornia, Rosignoli, and Tiberti 2009), to the author's knowledge the only such exercise undertaken on this scale, supported this finding retrospectively for the period 1980–2000—thus, well before the economic crisis that spread across the world in 2008. The rest of this section of the entry describes the most important pathways of influence.

The political scientist Chantal Blouin and colleagues (2009) provide a useful overview of how trade liberalization can affect health adversely by way of its social determinants. One important pathway involves increases in economic inequality and insecurity, concentrated among workers whose livelihoods are placed at risk by low-cost, sometimes subsidized imports or competition from lower-wage jurisdictions as production is reorganized across multiple national borders to take advantage of opportunities for "labour arbitrage" (Ong 2006, 161). Another, of special interest given the rapidly rising burden of diet-related noncommunicable diseases in LMICs (Beaglehole, Bonita, Horton, et al. 2011), involves the ease with which supermarkets, manufacturers of high-fat, high-calorie processed foods, and fast food chains have expanded into new markets under liberalized trade and investment regimes (Hawkes 2006; Rayner, Hawkes, Lang, and Bello 2007; Clark, Hawkes, Murphy, et al. 2012). A third involves reductions in fiscal capacity (and therefore in resources for public investment in areas like education and health care) associated with tariff reductions, which have often taken place well before governments could develop alternative revenue streams (Baunsgaard and Keen 2005; Glenday 2006; Baunsgaard and Keen 2010). This is necessarily a stylized view; the English-language research literature, at

least, on country experiences related to trade and social determinants of health, remains uneven. There is little question about the adverse effects on access to essential medicines of intellectual property protection required under TRIPS and, especially, bilateral and regional trade agreements that provide more extensive ("TRIPS-plus") protection (Kerry and Lee 2007; Shaffer and Brenner 2009).

Governments have pursued trade liberalization for a variety of reasons. Some no doubt were genuinely convinced that a rising tide of trade-related growth would lead to widely shared improvements in well-being, although such improvements have often not materialized. Part of the explanation for the pursuit of trade liberalization reflects efforts by governments of high-income countries to open up new markets and opportunities for investment. This objective was central to the incorporation of IP protection into trade agreements (Sell 2003); an earlier instance involves "structural adjustment" lending by the International Monetary Fund (IMF) and the World Bank. Starting around 1980, the loans in question were designed to enable heavily indebted LMICs to reschedule their debts to external creditors. These creditors included major banks that had lent recklessly during the 1970s, to national governments that borrowed almost as recklessly, creating fears about the stability of the US financial system, in particular, when recession and high interest rates driven by US monetary policy after 1979 threatened debtors' ability to pay. The loans were accompanied by a relatively standard package of conditions grounded in textbook macroeconomics, including privatization of state-owned assets and lowering of barriers to imports and foreign investment, intended to reorganize national economies around sectors in which their exports were most competitive in order to protect their ability to repay creditors. One reflection on this period noted: "An alliance of the international financial institutions, the private banks, and the Thatcher-Reagan-Kohl governments was willing

to use its political and ideological power to back its ideological predilections" (Przeworski and ESST 1995, 5).

Although the policies in question were unevenly applied, their destructive effects on livelihoods and child welfare were documented as early as 1987 by a multicountry United Nations Children's Fund (UNICEF) study (Cornia, Jolly, and Stewart 1987). Subsequent reviews of the evidence found a preponderance of negative effects on health (Breman and Shelton 2007; Stuckler and Basu 2009) and probably understate these effects, because it is often difficult and costly to capture long-term health consequences of deteriorating socioeconomic conditions using epidemiological study designs (Pfeiffer and Chapman 2010). Structural adjustment often reduced public spending on health systems, with the World Bank contemporaneously promoting a model in which public provision and financing represented a residual last resort (World Bank 1993). A research team undertaking to rebuild elements of Tanzania's health system on a minuscule budget observed in 2004 that "the era of structural adjustment may be over, but the effects of earlier damage continue to cast a long shadow" (de Savigny, Kasale, Mbuya, and Reid 2004). The era may indeed not be over: even before the economic crisis of 2008, the IMF functioned as a gatekeeper for access to various forms of development assistance, insisting on macroeconomic orthodoxy that included limits on public spending for health and education even when short-term availability of donor funding had been assured (Sachs 1998; Working Group 2007).

The IMF has also consistently insisted that LMICs remove capital controls that limit short-term flows of financial investment (Stiglitz 2004). Meanwhile, high-income countries deregulated their financial industries in response to pressure from powerful domestic interests (Helleiner 1994). In the global financial marketplace that emerged, owners of financial assets constitute a "sort of global, cross-border economic electorate" (Sassen 2003, 70) capable of

constraining domestic policy and undermining national currencies and economies by shifting their assets across borders, with consequences that a former head of the IMF described as "swift, brutal and destabilizing" (Camdessus 1995; see generally Schrecker in press). The post-2008 financial crisis demonstrated a new form of interconnectedness: domestic deregulation and predatory lending and securitization practices in the United States and the United Kingdom triggered a worldwide recession and generated adverse effects both for people living half a world away and those living near the epicenters of the crisis, like the estimated 14 million US households dispossessed by foreclosures (Sassen 2011). The crisis is likely to have negative effects on health through multiple pathways (Ruckert and Labonté 2012), including public sector austerity measures necessitated (or at least, lent an aura of inevitability) by the combination of reduced tax revenues and the costs of bailouts and fiscal stimuli.

<h1>Global(izing) Markets for Health Care and Research</h1>

As noted earlier, global diffusion of medical technology is a positive element of globalization, although its benefits have been attenuated by the effects of economic integration and future progress is rendered uncertain by intellectual property issues and questions about financing. Structural adjustment's debilitating effects on access to health care are now being addressed, in many jurisdictions, by explicit efforts to provide universal health insurance coverage (Reich and Takemi 2009), although the extent of support from key sources of external finance remains uncertain. Against this background, four emerging global markets that are specific to health care must be considered.

The first, cross-border travel for medical treatment, is the topic of a separate entry so will not be discussed further. The second, best comprehended in conjunction with the first (Connell

2011), is the market for health professionals who migrate from poor to rich countries and, within countries, from poorly funded public health services to the private sector or to programs financed by external aid. Sub-Saharan Africa, the world's poorest region and the one where shortages of health professionals are most acute, is also most affected by their outmigration (Chen, Evans, Anand, et al. 2004; Connell, Zurn, Stilwell et al. 2007). The attraction of outmigration from countries that may offer only low and precarious pay and working conditions unimaginable in destination countries (Dugger 2004; Sachs and Sachs 2004) is easy to understand. Such "push factors" may have originated with structural adjustment conditionalities and their newer incarnations. Notably, IMF demands for expenditure restraint meant that "thousands of trained nurses and other health workers remain[ed] unemployed" in Kenya around 2006, and thousands more had left the country in search of work elsewhere, "despite a health worker shortage across all health programs" (Korir and Kioko 2009, 2). Some observers view the effects on national health systems as serious enough to justify treating high-income country recruitment of health professionals from sub-Saharan Africa, which persists despite efforts at voluntary restrictions, as "an international crime" and human rights violation (Mills, Schabas, Volmink et al. 2008). This problematic issue is one among many that raise questions of cross-border obligation and global justice, discussed in the final section of the entry.

Third, clinical research has become globalized, with the rise of private, for-profit contract research organizations and the emergence of sites outside the high-income countries as preferred locations for clinical trials (Glickman, McHutchison, Peterson et al. 2009; Petryna 2009). The attractions start with lower cost: a 2005 article noted that running a trial in Romania costs one-tenth as much per patient as in the United States, and quoted a pharmaceutical CEO as saying that "globalization is the ultimate arbitrage for companies" like his (Lustgarten 2005; see also

Petryna 2007). Many developing and transition economies offer more patients, sicker patients, and patients too poor to be receiving an existing treatment. Recruitment can be aided by lack of access to care, for all but the rich, outside the environment of the clinical trial—complicating, to put it mildly, the nature of informed consent when the usual standard of care is no care at all (Angell 1997; Kent, Mwamburi, Bennish et al. 2004). Offshoring of clinical trials is likely to accelerate as LMIC governments, notably India's and China's, build economic strategies that include the pharmaceutical industry and view their large patient populations and diversity of diseases as a source of comparative advantage for domestic producers and as a way of attracting foreign investment. Writing about the growth of a clinical trials industry in China in parallel with the marketization of access to health care, the sociologist Melinda Cooper coined the term "experimental labour" to clarify how "value is created in the emerging biomedical economies," warning about the limits of conventional bioethics analysis that "even if the liberal contract of informed consent had been implemented, it could only serve to facilitate a labour relation in which the labourer has 'nothing left to sell but exposure itself'" (2008, 88).

A fourth and final global market is that in human organs—the topic of urban legends, but now documented beyond serious dispute (Scheper-Hughes 2003; 2006; 2011). The most extensive survey available estimated that 5 percent of all transplant recipients worldwide in 2005 "underwent commercial organ transplants overseas" (Shimazono 2007). The organ trade is highly complex and inherently globalized, involving recruiters, brokers, and transplant surgeons (some working out of highly reputable hospitals) in multiple countries and requiring a certain level of official indulgence. It allows the relatively affluent to cross borders and invade the bodies of people living on the margins, dislocated by macro-scale economic and political processes outside their control. The anthropologist Nancy Scheper-Hughes, whose extensive

fieldwork is foundational, identifies kidney sellers as "stranded Moldovan and Romanian peasants, Turkish junk dealers, Palestinian refugees, AWOL soldiers from Iraq and Afghanistan, unemployed stevedores of Manila's watery slums and Afro-Brazilians from the favelas and slums of Northeast Brazil" (2006, 20). The organ trade and the form of arbitrage on which it is based represent a predictable, if chilling, stage in the expansion of market logics into all areas of human interaction, across national borders. Like consent to participation in LMIC clinical trials and many other "free" exchanges in the global economy, notably including the negotiation of trade agreements between large and small economies (Stiglitz and Charlton 2004), it is carried out under conditions of vastly unequal resources and bargaining power.

<h1>Expanding Bioethics' Frame of Reference</h1>

In the global frame of reference, bioethics confronts inequalities much more dramatic than those that normally occur within the borders of high-income countries, although there are exceptions (compare Reynolds 2010). How meaningful is informed consent to participation in a clinical trial when it is the only chance for access to care, and what policies are appropriate for such situations? Can priority-setting for preventing death during pregnancy and childbirth, which is now extremely rare in the high-income world, be ethically meaningful within a budget of 50 cents per person per year (Prata, Sreenivas, Greig et al. 2010)? One approach is to view these inequalities either as tragic, in the literary sense of inevitability, or outside the appropriate scope for ethical inquiry. An alternative perspective asks about global justice and health, emphasizing that many inequalities of greatest concern are the consequence of policy choices that could have been made differently. Ethical analysis can take these choices as given, or it can question those choices and the social arrangements that give rise to them. Viewed through the conceptual lenses

of contemporary North American bioethics, structural adjustment and similar efforts to create a global marketplace constitute large-scale social experiments on nonconsenting populations, or at best populations whose consent has been imperfectly obtained. The political scientist Adam Przeworski has commented: "Every time I apply for a government research grant, I am required to sign a form declaring that I will not experiment on human subjects. I wish governments had to do the same" (1993, 51).

Encouragingly, some bioethicists are now expanding their frame of reference to include questions directly related to globalization, such as the global justice dimensions of transnational migration of low-paid, predominantly female care workers (Eckenwiler 2009; Meghani and Eckenwiler 2009) and the inequalities in access to health care that are inevitably magnified by transplant tourism (Turner 2007; 2008; 2010). Julia Bertomeu describes this as a process of evolution "toward a more political, institutional, and historically anchored" model of bioethics (2009, 33), although she may be too optimistic about the pace of progress. In order to respond adequately to the empirics of globalization, bioethics—and the enterprise of normative ethics in general—will need to address more directly the role of political institutions and engage with the work of political philosophers (Jaggar 2009). Especially noteworthy in this regard is the work of Thomas Pogge, whose argument about ethical responsibility for extreme poverty—here presented in necessarily oversimplified form—addresses the impoverishment of entire societies and the limited availability of resources needed to improve the health of their populations. Pogge bases his argument on the negative duty to avoid causing harm and the way in which economic institutions routinely fail to respect that duty (Pogge 2007b). "By avoidably producing severe poverty, economic institutions substantially contribute to the incidence of many medical conditions. Persons materially involved in upholding such economic institutions are then

materially involved in the causation of such medical conditions" (Pogge 2004, 137). For Pogge, ethical responsibility for harms like those associated with extreme poverty follows causal responsibility across national borders, subject only to the proviso that plausible alternative sets of institutions that would be more conducive to reducing or eliminating poverty must exist.

This test is not difficult to meet: consider the UNICEF study's prescription for economic "adjustment with a human face" (Cornia, Jolly, and Stewart 1987). Generically, globalization in its current form is organized around the proposition that markets are the normal and natural basis for all forms of human interaction, from which any departure demands justification, and that the most important role of government is to create and sustain the conditions under which markets can function (Babb 2005; Ward and England 2007; Somers 2008, 63–117). From an ethical perspective this proposition must be contested; alternative conceptual frameworks are provided by, for example, the economist Dani Rodrik's (2001) scenario of how different the world trade law regime would look if it were genuinely intended to maximize opportunities for economic development, and Pogge's own proposals for mechanisms to finance pharmaceutical research that address problems created by harmonized intellectual property protection and also the more basic question of how to support research on diseases of the poor, who are by definition not an attractive market for private firms (Pogge 2007a; 2009).

Pogge's argument and similar views on cross-border obligations (see, e.g., Young 2006) do not reflect a consensus position. Thomas Nagel (2005), for instance, is eloquent on the moral arbitrariness of accidents of birth that determine whether one has the opportunity for long and healthy life, yet he rejects conceptions of global justice that entail obligations to remedy the human consequences, claiming that "socioeconomic justice is different" from norms such as "bodily inviolability" that "set universal and prepolitical limits to the legitimate use of power"

(Nagel 2005, 127). For Nagel, obligations related to socioeconomic justice can arise only within the framework of political relationships and accountabilities that characterizes the nation-state. (Like my description of Pogge's argument, this is a considerable oversimplification.) However, what we know about health and its social determinants calls into question the idea that a clear boundary can be defined between socioeconomic justice and other, more fundamental kinds, especially (but not only) in the contexts of extreme poverty with which Pogge is concerned. Even in wealthy societies, being at the bottom of multiple social hierarchies wears an individual out in biologically measurable ways (Marmot 2004; Geronimus, Hicken, Keene, and Bound 2006). Further, the historical legacy of colonialism and uneven development and today's multiplicity of cross-border economic flows and transactions arguably combine to create what Darrell Moellendorf calls a "global association" (2002, 31) sufficient to give rise to claims of distributive justice across borders. And it seems frankly perverse to reject considerations of justice, and the associated obligations, in the international frame of reference when many powerful actors on the world economic stage are far *less* accountable to those whose health and well-being are adversely affected by their decisions than are national governments, at least in formal democracies. To return to Przeworski's analogy with human subjects research, certainly in research ethics one would not use the lack of an adequate institutional framework for securing and granting consent as a reason to abandon ethics review.

Finally, globalization sensitizes us to the need for methodological self-consciousness, and for bioethics itself to become a topic of critical social scientific study. It is sometimes forgotten that the canonical "four principles" reflect a specific set of political and bureaucratic circumstances and a distinctive social context in the United States (Fox 1994; Evans 2000; Beauchamp 2003). The same can be said of the intellectual content and institutional development

of bioethics in other settings. Thus, a collection of papers dealing with nine LMICs and five high-income countries edited by Catherine Myser (2011) explores intriguing contrasts such as those between Western individualized value systems and non-Western ones that remain widespread in India despite post-1991 economic liberalization; the importance of historical context (e.g., the role of the Catholic church and of exploitative economic development in much of Latin America, variations in the role and allegiances of the medical profession); and external influences such as World Bank and IMF promotion of health care privatization as well as the "export" of North American perspectives. In countries rich and poor alike, bioethics is often contested political terrain, but it can also function as a means of (or resource for) political contestation. These issues cannot be explored further here; they are raised simply to show how a global frame of reference facilitates consideration of bioethics as a social practice that must be understood in relation to the settings in which it is carried out.

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